JUNE 1999

FRONTLINES

LINKING ALCOHOL SERVICES RESEARCH AND PRACTICE

Monitoring the Performance of Alcohol Treatment Systems

By Enoch Gordis, M.D., Director, NIAAA

Assessing and evaluating the performance of alcohol treatment providers have always been important, yet these responsibilities have become even more critical in today's rapidly changing health care system. As our nation's health care dollars are stretched farther and farther, providers of alcohol and other behavioral health services are being asked to demonstrate their efficiency and effectiveness. There are signs of progress in measuring performance. However, the necessary tools and methods are still in their infancy.

This edition of *FrontLines* focuses on an area that NIAAA sees as quite crucial: monitoring the outcomes and measuring the performance of alcohol treatment providers, organizations, and service systems. Although consumers and other stakeholders have asked many questions, there are relatively few research results that can provide answers.

Jean Miller, commissioner of the New York State Office of Alcoholism and Substance Abuse Services, and E. Clarke Ross, the former executive director of the American Managed Behavioral Healthcare Association, each examine this issue, raising provocative questions that illustrate the gaps in scientific knowledge and the need for definitive empirical evidence. Ms. Miller asserts that the standards for care in addiction services vary across states and across the managed care organizations that provide many of those services. She notes the importance of fostering collaborations to meet the complex needs of persons with alcohol problems and criticizes the fragmentation that is apparently increasing in many parts of the country. Dr. Ross contends that inconsistent standards across service systems have led to disparities in treatment quality for large segments of the population. He suggests several factors behind these inconsistencies.

Despite their different perspectives, both authors call for a common set of standards and metrics by which to evaluate alcohol treatment

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COMMENTARY

Monitoring the Effectiveness of Alcohol Treatment: Strategies for Linking Performance Measures to Outcomes

By A. Thomas McLellan, Ph.D., and James R. McKay, Ph.D.
University of Pennsylvania

Providers and advocates of treatment for alcohol disorders face mounting pressures from a variety of sources — including state and federal policy makers, insurers, and the general public — to produce empirical evidence of treatment effectiveness. These developments raise questions about how best to go about documenting the impact of alcohol and other drug abuse treatment. What is treatment supposed to accomplish? The most widely accepted goals are:

- ***Sustained reduction of alcohol and other drug use.*** This is the foremost goal of dependence treatment and the primary outcome domain.
- ***Sustained improvements in personal health and social function.*** Improvements in medical and psychiatric health and social function are important because they reduce the problems and expenses produced by addiction. In addition, improvements in these areas maintain reductions in alcohol and other drug use, including the likelihood of relapse.
- ***Sustained reductions in public health and public safety threats.*** The threats to public health and safety from abusing individuals come from

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A PUBLICATION OF THE NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM
IN CONJUNCTION WITH THE ASSOCIATION FOR HEALTH SERVICES RESEARCH

behaviors that spread infectious diseases and from behaviors associated with personal and property crimes.

Methodologies to Assesses Treatment Outcomes

Three methodological approaches may be used to assess the degree to which alcohol and other drug abuse treatment succeeds in achieving these three goals. Following is a description of each approach.

Clinical Tracking. The most commonly used methodology in experimental and naturalistic field studies of alcohol and other drug abuse treatment is clinical tracking (CT). Data on alcohol and other drug use and psychosocial functioning are gathered from clients through self-report questionnaires or clinical interviews, which at a minimum are administered at intake and at post-treatment follow-up. In some studies, information on treatment services received is also obtained from clients. The procedures used for this approach have been refined over time, and a wide variety of assessment measures with proven reliability and validity are available.

Unfortunately, this approach also has major limitations. First, to assure data validity, a representative sample of clients must be enrolled at treatment intake, with a follow-up rate of 70 percent or better. Otherwise, the data may not be interpretable. Second, because a follow-up interval is required, these studies take a fairly long time before results are available. Third, tracking, locating, and interviewing clients at follow-up are expensive and time-consuming activities.

Database Monitoring. Alcohol and other drug abuse treatments are expected to reduce the costs and negative social impacts produced by addiction. One way to assess the impact of treatment is to examine state databases — such as arrest records, incarceration records, welfare records, Medicaid claims for hospitalization, and employment records — that reveal the expression of social problems and continued costs. This approach to outcome assessment is referred to as database monitoring (DM).

DM systems have substantial cost and efficiency advantages over CT systems. They can be used to produce evidence that alcohol and other drug abuse treatment has achieved important social goals, such as reductions in crime, health utilization, and social impairment. Furthermore, these databases offer an opportunity to develop very good measures of costs, cost offsets, and savings.

There are, however, some problems with this method. For example, with the exception of readmission to treatment, DM systems offer no direct indication of whether former patients are still using or abusing alcohol and drugs. In addition, these systems are marked by a lack of treatment process information, long delays in the availability of many records, and difficulty comparing outcomes between programs or types of treatments because of inadequate "case mix" adjustment information. Finally, concerns have arisen about patient confidentiality in DM systems.

The achievement of initial abstinence and completion of treatment generally predict good long-term outcomes, but the "active ingredients" of treatment that actually bring about these favorable performance indicators are, for the most part, still unknown.

Performance Indicators. Because costs are a continuing problem in the monitoring of health outcomes — particularly in the addiction treatment field — there is great interest in the development of faster, less expensive means of evaluating the effects of treatment. The treatment field has begun to look for patient status and treatment delivery variables that can be easily measured during treatment or at the point of discharge and that are clearly associated with longer-term outcomes following treatment. Such variables could serve as "indicators" of "true" outcomes. These indicators typically have been developed by groups of clinicians or administrators from easily collected data that have a "face-valid" or intuitive link with longer- term outcomes. Examples include: ■ "the proportion of patients who are re-admitted to inpatient care within 30 days following inpatient discharge," ■ "the proportion of patients who drop out of treatment prior to the planned discharge date," and ■ "the proportion of patients who enter rehabilitation care within one week following detoxification discharge."

Patient satisfaction is an indicator that has become a standard in all areas of health care quality; it typically is measured via patient questionnaires.

Because these measures can usually be collected, analyzed, and reported rapidly and inexpensively, the performance indicator approach to outcomes monitoring has great appeal to patients, clinicians, and administrators alike. Because of their potential clinical and administrative value, "performance indicator monitoring" (PIM) systems have already been adopted by many treatment providers. In addition, widespread efforts are underway to build the reporting of these measures into existing clinical or management information systems. (See the 1998 annual report of the National Committee for Quality Assurance.)

Performance indicators for alcohol and other drug abuse treatment have been useful in identifying obvious problems in the conduct of treatment, in bringing the consumer perspective into the treatment setting, and in stimulating the treatment field toward greater self-examination and self-evaluation. At the same time, there is some concern that these initial indicators may only identify extremely poor outcomes, such as malpractice claims, and may not be sensitive to more subtle but clinically important treatment differences.

Even more serious is the possibility that some performance indicators might be manipulated to show appar-

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The Washington Circle Works to Develop Core Measures for Alcohol and Other Drug Services Within Managed Care

By Frank McCorry, Ph.D., Deborah Garnick, Sc.D., and Frances Cotter, M.A., M.P.H., The Washington Circle

Alcohol and other drug abuse is a medically and socially complex problem that requires aggressive screening and case-finding efforts, sustained treatment by skilled health care providers, and effective patient advocacy to overcome persistent social stigma. Monitoring the quality and availability of services is critical to ensuring that people with alcohol and other drug abuse problems receive proper treatment. Society at large also benefits, in terms of public health, public safety, and social welfare.

In March 1998, the Center for Substance Abuse Treatment (CSAT) Office of Managed Care at the Substance Abuse and Mental Health Services Administration (SAMHSA) convened the Washington Circle, a group of national experts in alcohol and other drug abuse, managed care, and performance measurement. This group is dedicated to improving the quality and effectiveness of alcohol and other drug abuse services through the use of performance measurement systems.

The Washington Circle has two major goals: ■ develop and pilot test a core set of performance measures for alcohol and other drug abuse treatment for public and private sector health plans; and ■ collaborate with a broad range of stakeholders to ensure widespread adoption of alcohol and other drug abuse performance measures by private employers, public payers, and accrediting organizations.

Washington Circle members recognized the importance of articulating an underlying set of values to inform their discussions and to guide their decisions. The Circle's value statement acknowledges both the needs and dignity of addicted people and their families and the responsibilities of the treatment field to respond to them.

The Circle's statement of values and the performance measures developed to date are described more fully in the Washington Circle Year 1 Report, released in March 1999. For a copy of the report, contact the CSAT Office of Managed Care, tel. 301/443-8976.

To date, the Washington Circle has identified a core set of eight process and outcome performance measures, of which three — screening, treatment engagement, and prevention among pregnant women — were targeted for initial development. For those measures, subcommittees worked to begin technical specifications, identify key issues, and make initial recommendations to the full group. Activity related to these measures continues.

Screening for Abuse

The subcommittee on screening decided to focus initially on alcohol misuse. The proposed measure calls for a survey of a random sample of enrollees to assess screening for alcohol misuse by health plans. The survey includes questions regarding: alcohol use and other health-related behaviors, alcohol screening in the past year, and counseling regarding alcohol use.

Alcohol misuse is associated with extensive morbidity and mortality that can be prevented if health plans use screening and primary care interventions to identify and counsel persons in need. Such prevention can result in considerable benefits and cost savings to society. Several brief screening questionnaires have proved effective for identifying alcohol misuse.

Treatment Engagement

Substance abuse treatment has been found to be as effective as treatments for other chronic, relapsing conditions. Literature on this subject indicates that, for alcohol and other drug dependence, more treatment is associated with better client outcomes.

Health plans can use their administrative files to determine whether individuals diagnosed with alcohol or drug abuse or dependence enter into a course of treatment. Specifically, plans can calculate the percentages of individuals who, within 30 days of diagnosis: ■ utilize at least three specialty alcohol and other drug abuse outpatient visits or at least three consecutive days in a specialty alcohol and other drug abuse inpatient/residential program, or ■ utilize at least three general medical outpatient visits for which diagnosis and/or procedure codes indicate alcohol and other drug abuse or dependence.

Prevention Among Pregnant Women

Alcohol and other drug use can have an adverse influence on the developing fetus and can result in both immediate and long-term costs to health plans, families, and society. The measure recommended by the subcommittee calls for selecting a sample of pregnant women enrolled in a health plan and administering a brief survey to them in their second trimester. The survey will be a standard self-report questionnaire to obtain information on alcohol use (and possibly tobacco use). The proportion of women reporting use above a designated level, compared with the number of pregnant women overall, will be reported on a yearly basis. Reductions in use would be determined by comparing the proportions within a specified health plan annually.

Measures for Future Development

Along with the three measures for which development was begun in 1998, the Washington Circle selected five additional measures as part of its core set: linked process and outcome measures, post-treatment reductions

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Establishing Performance Measures and Standards for Alcohol Services

By Jean Miller, J.D., New York State Office of Alcoholism and Substance Abuse Services

Using performance measures and standards, managed care is intended to provide comprehensive, quality services for enrollees by assuring appropriate levels and utilization of care. Using the same methods, managed care is also intended to reduce costs. But unless purchasers and providers of managed care can reach consensus on measures and expectations of care, some models that provide comprehensive, integrated health care services may deteriorate. The addiction treatment system is particularly vulnerable in a managed care environment that does not recognize state-licensed programs or reimburse non-medical or "wrap-around" services that are critical to recovery.

Alcohol treatment as a specialty recognizes that addiction is a multifaceted problem and that the services needed to treat addiction comprehensively must be multidisciplinary. As a result, treatment programs include staff from several disciplines; integration and comprehensive care are hallmarks of many alcohol treatment programs.

But managed care organizations (MCOs) do not always recognize or use the services provided by addiction treatment programs; nor do they always recognize the multidisciplinary staffing of such programs. For clients enrolled with these MCOs, the benefits of this comprehensive approach to treatment are lost. Care becomes fragmented. Treatment providers wind up having to respond to different eligibility criteria and standards for different MCOs, in addition to requirements by government or certifying organizations. This creates an enormous administrative burden for providers.

The federal government has established national standards for addiction treatment in only three areas: methadone treatment, use of the Center for Substance Abuse Treatment's (CSAT) block grant, and confidentiality regulations. Methadone treatment is highly regulated, with criteria for admissions, staffing, minimum services, physical plant, security, and shipping, among other things. Confidentiality regulations protect persons in treatment from being identified without their consent. Provisions governing the block grant primarily dictate how funds are to be used.

Amazingly, most large, multi-state MCOs develop and apply their own performance criteria without regard to what is already required by state licensing boards.

Disconnect Between State and MCO Requirements

State regulations generally cover such areas as admission criteria, level-of-care determinations, staffing requirements, utilization review, and physical plant. State standards may also address processes like record keeping, treatment planning, and discharge planning. These standards and regulations vary greatly across the country. Enforcement may be carried out at the state, county, or regional level. Even licensing practices vary. Some states license only funded programs; others license all programs. The purchase of managed care by public and private payers has compounded these differences.

Amazingly, most large, multi-state MCOs develop and apply their own performance criteria without regard to what is already required by state licensing boards. In the addiction treatment field, the use of performance measures and standards for quality assurance is greatly complicated by a limited number of measures, lack of consensus on what measures are appropriate for addiction treatment, and difficulties in obtaining needed data. Government standards at all levels have addressed program operations and processes, but they have not focused on individual outcomes.

Efforts are underway to bring order to this confusion. At the forefront is the Washington Circle, which is developing a core set of performance measures for public and private sector health plans. (See Organization Profile in this issue on page 3.) Success of this project will go a long way in providing good information on the quality and benefits of treatment and in streamlining the administrative burdens faced by providers.

Preserving Collaboration

The proposed standards, however, will not address the broader expectations of alcohol treatment in public health, criminal justice, and social welfare. Partly because of its comprehensive nature, addiction treatment has been critical in dealing with public health problems such as HIV/AIDS, tuberculosis, and sexually transmitted diseases. Will this capacity be preserved under managed care? The alcohol treatment system must work closely with social services systems, particularly in welfare reform efforts to place people in employment, and with the criminal justice system to provide services to addicted criminals.

A key question is whether these and other collaborations that together address all aspects of addiction can be preserved in a managed care environment and whether MCOs can — and will — respond to the public health, public welfare, and public safety needs of patients in addiction treatment. Efforts to develop performance measures and standards for the addiction treatment field should support and even try to strengthen collaboration, service integration, and multidisciplinary staffing in treatment programs.

Performance Quality and Patient Protection: One Set of Standards for All Patients

*By E. Clarke Ross, D.P.A., National Alliance for the Mentally Ill**

For far too long, health care in the United States has been provided through two distinct systems that reflect different levels of care: a first-class, commercial, and privately paid system of care and a second-class, publicly owned and operated, or largely under-financed system of care. Managed care, many believe, can help to soften or even eliminate the lines of distinction between "private" and "public" systems of care and develop a single requirement for accountability in both quality performance and patient protection.

The 1997 Budget Reconciliation Act (P.L. 105-33) presented a wonderful opportunity to move the U.S. health care system toward uniform accountability for quality performance and patient protection. Unfortunately, Congress decided instead to perpetuate multiple classes of care. Under consideration in the 1997 budget act were managed care standards for Medicare and Medicaid. In a few areas of quality assurance and patient protection, such as immediate access to emergency care and prohibition of so-called "gag clauses," Congress enacted the same standards for both Medicaid and Medicare. But in most areas, the standards are different.

Consider these differences. States may enroll Medicaid-eligible individuals into managed care plans regardless of the individual's preference. Medicare managed care enrollment, on the other hand, is completely voluntary. Medicaid enrollees can terminate their enrollment in a managed care organization (MCO) only once a year; Medicare enrollees may disenroll at any time. Medicare enrollees are entitled to very specific information about the health plans they are considering, but information received by Medicaid enrollees about their plans is much less specific. Under Medicare, managed care enrollees have strong grievance and appeals rights; not so for Medicaid enrollees. Medicare-financed health plans must meet detailed quality assurance standards; Medicaid-financed plans are to meet some unspecified standards to be developed by each state. Medicare-financed plans are subject to detailed inspections by independent and external quality reviewers. For Medicaid plans, an external entity will conduct annual reviews using standards developed by each state with the Health Care Financing Administration.

Why the differences in expectations and accountability? The official reason is federalism: Medicaid is a federal-state program that must reflect each state's needs and priorities, while Medicare is a federally funded program. But underlying this justification is the real reason: Medicare beneficiaries are taxpayers; people receiving Medicaid are poor.

This differentiation continues in many other forms. For example, accreditation standards issued in 1997 by the National Committee for Quality Assurance (NCQA) applied only to managed behavioral health care organizations, the so-called "carve-outs." But MCOs that deliver behavioral health care services as part of a comprehensive plan had an additional three years to comply with these standards. Congress is now debating patient protection legislation. Will these protections apply to all privately financed health plans? To what extent will employer self-financed plans covered under ERISA continue to be exempt from these requirements? Apparently there is little if any support to develop and apply a uniform set of standards for all health plans, regardless of their financing.

In the public behavioral health services arena, many advocates support a nationwide performance system so that consumers and their families can compare performance among states and counties. But state and county officials argue that each locality is unique and should be able to use whatever performance system, if any, that it chooses.

Managed care offered the opportunity to move health care delivery in the United States toward a single system of quality assurance and patient protection. But concepts like federalism and attitudes and biases linked to payment sources continue to undermine this goal. How much longer will we permit these differences — and the inequities they foster — to continue? Why should quality, performance, and patient protection mean different things for different people?

**Formerly executive director of the American Managed Behavioral Healthcare Association.*

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in the current managed care environment. This observation is particularly compelling because we have so much to learn about how well the current treatment system serves persons with alcohol problems.

In the Commentary, A. Thomas McLellan and James McKay provide a succinct description of the questions germane to documenting the impact of alcohol treatment and address some major approaches to reaching useful answers. Frank McCorry, Deborah Garnick, and Frances Cotter discuss the ongoing efforts of the Washington Circle to develop and disseminate the tools necessary for evaluating these treatments. Finally, Thomas McGuire, Lynn Duby, and Lee McGuire describe the impact of performance-based contracting on the provision of alcohol services in the state of Maine.

I expect that you will find the questions raised in this edition of *FrontLines* to be thought provoking and I hope that the answers will be useful.

Performance-Based Contracting in Maine Spurs Upward Trends in Service Effectiveness and Efficiency

By Thomas McGuire, Ph.D., Boston University, Lynn Duby, M.S.W., Maine Office of Substance Abuse, and Lee McGuire, University of Missouri

Maine's implementation of performance-based contracting (PBC) for providers of alcohol and other drug abuse services has led to overall improvements in service effectiveness and efficiency, according to data from the State Office of Substance Abuse (OSA). PBC allows the state to evaluate service providers in terms of efficiency, effectiveness, and service delivery to special populations, so that it can better allocate limited treatment funds.

In July 1991, OSA began including performance monitoring in its contracts with treatment providers, so that it could pay them based on their results. The contracts require detailed income and expenditure budgets, which are used to determine the level of contracted services and payments. In 1992, OSA introduced performance standards, and in 1993 it began to hold alcohol and other drug abuse treatment providers accountable for their performance. Since implementation of PBC, OSA has required contracting agencies to provide detailed information about treatment outcomes for specific clients. In 1994, OSA informed providers that their performance results from the previous year could affect current-year contract allocations.

Under PBC, performance results may affect the total contract dollar amount used to determine the percentage or total units of service that OSA will purchase. Providers who meet performance standards and stay within budget are rewarded by this system, which allows them to retain surplus funds. A provider who does not meet standards is not permitted to keep surplus funds, and it could lose OSA funding for the next year.

Minimum Performance Levels Spelled Out

Most of the data used to measure program performance come from OSA's standardized admissions and discharge database, the Maine Addiction and Treatment System (MATS), which tracks performance indicators in three areas: efficiency, effectiveness, and service delivery to special populations. Contracting providers must meet minimum levels of performance in each of these areas. The contract includes separate performance standards for each type of service provided. Although different modalities often share common indicators, they are required to meet different minimum standards and numbers of indicators.

Under PBC, performance results may affect the total contract dollar amount used to determine the percentage or total units of service that OSA will purchase.

Efficiency standards measure service utilization. To meet efficiency standards, programs must deliver a modality-specific percentage of units. Outpatient standards also specify how units of service are to be broken down into services to primary clients and to co-dependents.

Effectiveness standards measure the percentage of a treatment program's clients who experience "good" outcomes. The standards include self-reported measures of drug use, employment and employability, lack of criminal involvement, and reduction in problems with family or employers. Performance must remain at or above minimum levels for a specified number of indicators. For example, each outpatient program must meet the minimal standard for at least eight of the 12 effectiveness indicators; otherwise, it is considered a low performer.

Special population standards measure service delivery to target populations, including women, adolescents, the elderly, and multiple-drug and IV-drug users. Again, contracting providers must meet minimum performance standards for a certain number of indicators to be in compliance.

Data Demonstrate Positive Trends

According to data from MATS, efficiency performance of outpatient and residential programs has improved over the course of PBC implementation, with residential programs showing the greatest improvement. Only 24 percent of residential programs performed according to OSA's efficiency standard at the beginning of PBC; by the end of fiscal 1994, 67 percent met the efficiency requirement. Approximately 14 percent of outpatient programs met the efficiency standard in the second quarter of fiscal 1990, compared with 40 percent at the end of fiscal 1994. These percentages fluctuated considerably from quarter to quarter, with both increases and decreases, especially among outpatient programs.

Effectiveness performance of residential and outpatient programs presented an upward trend, again, with substantial movement between quarters. Implementation of performance measurement for four new indicators in April 1990 had a large effect on outpatient provider performance. Those indicators measured reduction in problems with spouse or significant other, problems with other family members, problems with employer or school, and absenteeism. The percentage of outpatient programs that met the required number of standards dropped from roughly 50 percent to close to 5 percent at the beginning of fiscal 1991. By the end of fiscal 1994, however, outpatient performance

compliance increased to over 45 percent. Effectiveness performance of residential programs rose and fell throughout the period, but increased from an overall compliance rate of more than 30 percent to more than 50 percent. Although the compliance rate at the end of fiscal 1994 indicates improvement, there was not clear evidence of a consistent upward trend.

Analysis of the data between 1989 and 1994 also indicates a wide gap between outpatient and residential programs in performance for special populations. Outpatient performance held at about 33 percent compliance in fiscal 1990 and fiscal 1994. For two years in between, however, the percentage of outpatient programs that met the standard for special populations was at or below 20 percent. Residential programs trended slowly upward, from 60 percent in 1990 to 91 percent in 1994. For the final two fiscal years, however, the percentage of programs in compliance seesawed.

On average, prior to PBC, programs delivered more services than contractually required. After PBC began, programs delivered almost exactly the contracted quantity of services. There is also a significant difference in the mean overall effectiveness score. Before PBC, programs met half of the applicable effectiveness indicators. Since PBC, the average is 0.59. Improvements were evident in the indicators for alcohol and other drug abuse and employment; however, mean scores for indicators measuring criminal involvement and family functioning showed either insignificant improvements or fell slightly after PBC began. Time in treatment rose from an average of 48 to 61 days.

These results are encouraging. Still, this research relied on performance as reported by each agency. Because of changes in reporting practices, gaming is a possibility and it is necessary to examine the OSA data from another perspective. This remains an issue for ongoing research.

For more information, please contact Lynn Duby, tel. 207/287-6342, e-mail Lynn.Duby@state.me.us

Reference: Commons, M., T.G. McGuire, and M.H. Riordan. Performance Contracting for Substance Abuse Treatment. (Health Services Research, 32:5, 1997).

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ent — but not real — improvement. However, the treatment outcome literature provides evidence that several variables generally available in high-quality management information systems can predict post-treatment outcomes from addictions treatment, and could therefore serve as performance indicators.

More Assessment Options Can Mean More Confusion

The availability of different assessment methodologies, as well as reliable and valid outcome measures in a number of domains, are positive developments. However, more assessment options can also lead to greater confusion, particularly for those in public policy and administration. For example, an evaluation of a treatment program that focused on selected performance indicators might conclude that the program had very good outcomes because clients received more services and were retained longer than clients in other programs. On the other hand, a clinical evaluator who interviewed a sample of patients at admission and again six months following discharge might decide otherwise, depending on the outcomes. If only 40 percent of the patients were abstinent following treatment but frequency of drinking fell 70 percent and medical and psychiatric symptoms dropped by 50 percent, the evaluator might conclude the program had only mixed outcomes. Finally, a policy analyst using Medicaid admission and discharge data to compare inpatient utilization rates might conclude that treatment had a very poor outcome because there was no decrease in utilization, and hence no cost offset to the public.

This example illustrates two points. First, these three program assessors, which represent common perspectives on outcome, have different purposes and different expectations regarding treatment. Furthermore, they measure different elements of the treatment process and at different points in time. Second, because of these conceptual and measurement differences, it is possible that different outcome evaluations of the same program will arrive at different conclusions. An important challenge for outcomes evaluation research is to better delineate the relationship between the clinical tracking, database monitoring, and performance indicator approaches, and to determine the circumstances under which the three methodologies are likely to produce similar or dissimilar results.

Issues for Future Research

More information on the specific treatment processes and goals that produce better outcomes is needed for the further evolution of performance and outcomes measurement. Some of this information will come from concurrently applying all three measurement approaches in the same samples, to determine the nature and extent of the relationships of the findings from each approach.

Although we know that the achievement of initial abstinence and completion of treatment generally predict good long-term outcomes, the "active ingredients" of treatment that actually bring about these favorable performance indicators are, for the most part, still unknown. This type of research has great potential for helping clinicians develop more robust and potent interventions. Research is also needed to validate existing criteria for placing patients at treatment admission and for transferring or discharging patients between levels of care.

NIAAA Update

Three NIAAA Program Announcements (PAs) are soliciting grant applications on alcohol-related health services research. The most recent PA, released on Sept. 16, 1999, targets "Cost Research on Alcohol Treatment and Prevention Services" (PA-98-104). Responses may include a broad range of cost analytic and economic studies. Another specialized PA seeks applications for "Secondary Analysis of Existing Health Services Data Sets" (PA-97-066). Responses must propose analyses of already collected data and are limited to two years of support. Finally, the general announcement on "Health Services Research on Alcohol-Related Problems" (PAS-98-037) seeks proposals for research that examines the impact of the organization, financing, and management of alcohol-related health services on the quality, cost, and outcomes of care and access to care. The full text of these PAs may be found on the NIAAA web site at <http://www.niaaa.nih.gov> or, more directly, at <http://silk.nih.gov/silk/niaaa1/grants/program.htm#announcement>.

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in alcohol and other drug use, duration of care, utilization of alcohol and other drug abuse services, and linkages to primary care.

In 1999, several of these measures will be targeted for technical specification.

For the Future

In its second year, with continued support from CSAT, the Washington Circle will continue activities begun in 1998: ■ stimulate efforts to pilot test measures that have been developed; ■ develop and begin to implement a strategic plan for the application and marketing of performance measures; and ■ identify and engage a broad range of stakeholders in this process.

The Washington Circle is coordinating its efforts with others in the field who are developing and implementing performance measures. Through collaboration and dialogue, the Circle intends to build upon existing performance monitoring systems and data sets to ensure more meaningful measurement of alcohol and other drug abuse services.

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FrontLines is published twice a year by the Association for Health Services Research. For further information contact AHSR at 202/223-2477.